Supreme Court, U.S.
FILED

No. 05-946

In The

Supreme Court of the United States

IRENE M. GESCHKE, INDIVIDUALLY AND AS EXECUTOR OF THE ESTATE OF CLARENCE O. GESCHKE,

Petitioner,

v.

AIR FORCE ASSOCIATION AND MONUMENTAL LIFE INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED FOR REVIEW

Whether a federal appellate court may affirm a summary judgment entered in favor of a medical insurer despite controlling state law requiring ambiguous provisions in insurance policies to be construed in favor of insureds, including those paying for coverage against skyrocketing costs of medical treatments.

PARTIES TO THE PROCEEDING

Irene M. Geschke, Individually and as Executor of the Estate of Clarence O. Geschke; the Air Force Association; and Monumental Life Insurance Company.

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PETITION FOR CERTIORARI

Petitioner, Irene M. Geschke, respectfully requests issuance of a writ of certiorari to review the Judgment entered in this case by the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The Seventh Circuit Court of Appeals selected its opinion in this case for publication in the Federal Reporter, where it is reported at 425 F.3d 337. The district court's unpublished memorandum opinion in this case is reprinted in the Appendix (App. 18-23).

STATEMENT OF JURISDICTION

Judgment was entered by the United States Court of Appeals for the Seventh Circuit on September 23, 2005. An order denying rehearing was entered by the Court of Appeals on October 20, 2005. Jurisdiction is based on 28 U.S.C. §1332 (App. 5-6) and §1291.

STATUTORY PROVISION

Rule 56 of the Federal Rules of Civil Procedure for the United States District Courts, 28 U.S.C.A.

STATEMENT OF THE CASE

The Petitioner's husband received from Respondent Air Force Association (hereinafter, "AFA") in April 1997 a letter and a brochure (in original record as R.46 Exhibits 6 and 7) promoting "CancerCare, our group cancer insurance plan." AFA's letter states that CancerCare pays "cash benefits" for "the many expenses associated with cancer *treatment*." (Emphasis added.) AFA's brochure states that CancerCare pays "Up to $500 for blood and plasma per illness period. *There is no maximum benefit for leukemia.*" (Emphasis added) (App. 3), and that "You and each of your insured family members are provided a lifetime benefit of $250,000." The brochure identifies the CancerCare plan's underwriter: Monumental Life Insurance Company, of Baltimore, Maryland.

Petitioner's husband enrolled himself and Petitioner in CancerCare, in May 1997. (App. 1-2) He was diagnosed with leukemia in March 1999, from which disease he died on June 21, 1999. (App. 3)

Petitioner resubmitted to Monumental in October 1999 her husband's claim for $37,622 in medical costs covered by the CancerCare plan. (App. 3) Of that amount, $33,689 related to her husband's treatments involving blood and blood plasma. (App. 1, 3) Monumental paid only $1,245 for those treatments. (App. 3) Monumental subsequently disclosed to Petitioner, for the first time, that where the CancerCare policy's "Blood and Plasma Benefit Rider" states that it pays a benefit for "incurred expenses for the cost of blood or blood plasma" that means that it "does not cover processing or administration fees, supplies, drugs, or laboratory charges associated with the cost of blood." (R.46 Ex. 35) (App. 3-4) But

this coverage limitation is not declared anywhere in the CancerCare promotional materials, CancerCare application form, certificate of coverage, or group policy.

Petitioner filed her first Complaint against Respondents in April 2002, in the Circuit Court of the Nineteenth Judicial Circuit, McHenry County, Illinois, alleging breach of contract and fraud. (App. 2, 4) In July 2002, Respondents removed the case on diversity grounds to the United States District Court for the Northern District of Illinois, Western Division, pursuant to 28 U.S.C. § 1332 (App. 4, 5-6).

Following discovery activity, Respondents filed in September 2003 a motion for summary judgment (App. 2, 4). The motion argued, *inter alia*, that the "cost of blood or blood plasma" language in the CancerCare policy "Blood and Plasma Benefit Rider" is unambiguous and thus as a matter of law Respondents are not liable for Petitioner's claims.

Petitioner had produced all of her documentary evidence to Respondents, who in turn attached copies of many of those documents, as well as excerpts from the transcript of Petitioner's deposition, to their statement of material facts. (R.46) Petitioner in turn drew that evidence to the district court's attention in her response to the summary judgment motion.

The district court granted Respondent's summary judgment motion in July 2004. (App. 4-5, 15-23) The district court agreed with the Respondents that the CancerCare plan's overall purpose was to provide insurance benefits "to help with the high cost of cancer treatment" but held that "treatment" was not covered by the blood and plasma benefit. (App. 20-21) After construing the phrase "incurred expenses for the cost of blood or blood

plasma," the court concluded that the benefit could only cover the cost of the actual blood product (App. 21-22), not the costs of matching the blood type to the patient and then transfusing it into the patient. The court "decided as a matter of law that the terms of the Blood and Plasma benefit are unambiguous in the manner that defendants have asserted." (App. 23)

After entry of summary judgment, Petitioner discovered that the AFA had at some point between July 12, 2003 and July 24, 2004 altered its website's description of the CancerCare policy's Blood and Plasma Benefit as providing "up to $500 per illness period of actual charges for blood or blood plasma" to "up to $500 per illness period of actual charges for *pints of* blood or blood plasma." (Emphasis added.) Petitioner conveyed this new information to the district court in a Rule 59(e) motion for rehearing, which the court denied: "AFA's changes to its website discovered by the plaintiff post-judgment, do not show the contract language to be ambiguous." (App. 24)

Petitioner appealed the summary judgment to the Court of Appeals for the Seventh Circuit, drawing that Court's attention to her evidence in support of her claim to benefits under the Blood and Plasma Rider. The Seventh Circuit affirmed the summary judgment in favor of the Respondents. (App. 14)

ARGUMENT

The Seventh Circuit reviewed *de novo* the summary judgment entered in favor of Respondents, "employing the same methodology as the district court." (App. 8)

Accurate Reading of CancerCare Policy Supports Finding of Ambiguity in Language "Incurred Expenses for the Cost of Blood or Blood Plasma"

To support the district court's conclusion that the phrase at issue here – "incurred expenses for the cost of blood or blood plasma" – was not ambiguous "as a matter of law" (App. 23), the Seventh Circuit began by engaging in a sophisticated analysis of how the CancerCare plan group insurance policy's riders are, according to the Court, in fact separate and independent from the policy itself. But that notion is contradicted by the plain language of the policy (including its riders).

For example, the Court refers to the policy's "Extended Hospital Expenses Benefit Rider" as a "special rider" that "was available" and "that did, under limited circumstances, provide coverage for cancer treatment." (App. 10-11) That rider is not "special": The Court's assertion is contradicted by its earlier affirmation (App. 2-3) that "The [CancerCare] *policy* and its associated *riders* provided defined benefits for certain *expenses incurred in the treatment of cancer, such as hospitalization, hospice care, ambulance services, anesthesia, and blood and plasma*." (Emphases added.)

Nothing in that rider says or implies that a policyholder had a "choice" (App. 11) between benefits specified by that rider or "all other benefits provided under the policy." (App. 11) Nothing in the record (and the Court does not point to anything there) supports the idea that anyone enrolling in the CancerCare plan could have separately "purchased the Extended Hospital Expenses rider." (App. 11) No one "purchased" a CancerCare policy – which of course was a group insurance policy – and no one then proceeded to select from a menu of riders available

for purchase. There was but one CancerCare group insurance policy and those who enrolled in it became covered by all riders to the policy.

Similarly, the Court attempts to separate out the Blood and Plasma Benefit Rider by observing that "Only the blood products [i.e., blood and plasma] are mentioned in the [Blood and Plasma Benefit] rider." (App. 10) Well, so are "expenses for the cost of," so where does the Court's reasoning lead?

Finally, every one of those CancerCare plan policy riders specifically states that it "is a part of the policy to which it is attached." (Riders attached as Ex. D to Petitioner's Opening Brief to the Seventh Circuit) All the language in all of those riders relates back to the policy's terms and coverages. "All the provisions of an insurance contract, rather than an isolated part, should be read together to interpret it and to determine whether an ambiguity exists." *United States Fire Insurance Co. v. Schnackenberg*, 88 Ill.2d 1, 5, 429 N.E.2d 1203, 1205, 57 Ill.Dec. 840 (Ill. 1983). (App. 8-9)

So clearly the CancerCare plan group insurance policy is all about providing benefits for specified costs of treating cancer.

(The Court also engaged in the useless exercise of defining two terms – "blood" and "plasma" – whose meaning Petitioner had never disputed. [App. 10])

There is a complete absence of any support for the Court's holding that "the phrase '[incurred expenses for the] cost of blood or blood plasma' means the cost of blood or plasma only and not the additional costs associated with treatment-related services such as laboratory testing and transfusion." (App. 10)

The Court's analysis entirely fails to establish an absence of ambiguity, leaving Petitioner's position unrebutted: The phrase is just obviously ambiguous.

Controlling Illinois Law Mandates Construing Ambiguous Insurance Policy Language in Favor of Insured

Illinois law requires that provisions of an insurance agreement be interpreted in the factual context of the case. *Indiana Insurance Co. v. Pana Community Unit School District No. 8*, 314 F.2d 895, 900 (C.A.7 [Ill.] 2002).

If an insurance policy's terms are susceptible to more than one meaning, "they are considered ambiguous and will be construed strictly against the insurer who drafted the policy." *Commonwealth Insurance Co. v. Stone Container Corp.*, 351 F.3d 774, rehearing denied (C.A.7 [Ill.] 2003).

Under Illinois law, an insurance policy must be liberally construed in favor of the insured. *Community Foundation For Jewish Education v. Federal Insurance Co.*, 16 Fed.Appx. 462, 465 (C.A.7 [Ill.] 2001).

When competing reasonable interpretations of a policy exist, a court is not permitted to choose which interpretation it will follow, but must construe the policy in favor of the insured and against the insurer who drafted it. *Employers Insurance of Wausau v. Ehlco Liquidating Trust*, 186 Ill.2d 127, 141, 708 N.E.2d 1122, 1130, 237 Ill.Dec. 82, rehearing denied, on remand, 309 Ill.App.3d 730, 723 N.E.2d 687, 243 Ill.Dec. 384, appeal denied, 188 Ill.2d 563, 729 N.E.2d 495, 246 Ill.Dec. 122 (Ill. 1995).

Particularly in view of how completely the Seventh Circuit and the district court misread the CancerCare

policy, it is appropriate to note that judges in ruling on summary judgment motions are not to weigh evidence and determine the truth of the matter, but to determine whether a genuine issue exists for trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249, 91 L.Ed.2d 202, 206, 212, 106 S.Ct. 2505 (1986).

On the other hand, the policy language with its repeated reference to "treatment" could certainly cause a reasonable person to conclude that the CancerCare policy's Blood and Plasma Benefit Rider would pay benefits to cover the cost of treating leukemia with blood and plasma therapy. "The determination of whether the terms of an insurance policy are ambiguous is made by reference to a reasonable person standard; 'the test is . . . what a reasonable person in the position of the insured would understand [the terms] to mean.' *Id.* [i.e., *Allstate Insurance Co. v. Smiley*, 276 Ill.App.3d 971, 659 N.E.2d 1345, 1350, 213 Ill.Dec. 698 (2 Dist. 1995)]" (App. 8)

(The Court's misreading of the CancerCare plan policy has also led to a doubtful contribution to Illinois insurance law: "[5] **Insurance**. . . . [key symbol] **2484**. . . . Under Illinois law, supplemental cancer insurance policy's coverage provision for 'incurred expenses for the cost of blood or blood plasma' conferred coverage for cost of blood products or plasma only, not additional expenses associated with their transfusion." *Geschke v. Air Force Association and Monumental Life Insurance Co.*, 425 F.3d 337, 338 [C.A.7 2005])

Petitioner placed into the case record and before both the Seventh Circuit and the district court substantive evidence that Respondents distributed promotional materials intended to lead recipients into believing that the CancerCare plan provided coverages consistent with the

goal of care signified by the plan's name. For example, AFA stated in its pitch letter sent to Petitioner's husband in late April or early May 1997 (R.46 Ex. 6) that the CancerCare plan paid substantial benefits for expenses for treatment of cancer (following emphases have been added):

> "Cancer is being detected earlier, and there are many more successful *treatments*. But it is usually *extensive treatment*, requiring specialists, and the cost is high! That's where AFA's CancerCare can help. It pays supplemental cash benefits to help with *the many expenses* associated with *cancer treatment*, such as:

And the brochure (R.46 Ex.7) that accompanied the AFA's pitch letter cited a broad range of CancerCare benefits, including:

> "Blood and Plasma . . . up to $500. Up to $500 for blood and plasma per illness period. *There is no maximum benefit for leukemia.*" (Emphasis added.)
>
> "Lifetime Benefit. You and each of your insured family members are provided a lifetime benefit of $250,000."

Petitioner's position concerning the policy provision in question is also supported by common sense: What would CancerCare plan members, or any persons suffering from cancer, be expected to do with a container of blood? (App. 9) Treat their cancer by transfusing it into their body themselves? Of course not. People pay a medical facility to match blood to their individual blood type, to prepare them for transfusion, and to perform and monitor the transfusion.

Presence of Genuine Issue of Material Fact Should Have Barred Entry of Rule 56 Summary Judgment

Petitioner placed substantial evidence referenced in this argument before the Seventh Circuit (and the district court), relevant and credible evidence sufficient to a degree that could cause a reasonable person to adopt Petitioner's position that "incurred expenses for the cost of blood or blood plasma" encompasses the cost of providing treatment using blood or plasma. The fact that the phrase is at least ambiguous and should be construed in favor of Petitioner is a material fact because it underpins Petitioner's claims in her case against Respondents. The fact that Petitioner has substantial evidence to support her position concerning that phrase, and that Respondent rejects that position, creates a genuine issue.

On a motion for summary judgment, the nonmovant's evidence is to be believed, and all justifiable inferences are to be drawn in the nonmovant's favor. *Eastman Kodak Co. v. Image Technical Services, Inc. et al.*, 504 U.S. 451, 456, 119 L.Ed.2d 265, 277, 112 S.Ct. 2072 (1992).

"[S]ummary judgment will not lie if the dispute about a material fact is 'genuine,' that is, if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 91 L.Ed.2d 202, 205-206, 211-212, 106 S.Ct. 2505 (1986).

Trial courts should act cautiously in granting summary judgment, and may deny summary judgment "in a case where there is reason to believe that the better course would be to proceed to a full trial." *Anderson v. Liberty*

Lobby, Inc., 477 U.S. 242, 255, 91 L.Ed.2d 202, 207, 216, 106 S.Ct. 2505 (1986).

Summary judgment is a drastic measure and should only be granted if the movant's right to judgment is clear and free of doubt. *Traveler's Insurance Co. v. Eljer Manufacturing, Inc.*, 197 Ill.2d 278, 292, 757 N.E.2d 481, 491, 258 Ill.Dec. 792 (Ill. 2001).

Nevertheless, in this nation's courts "an atmosphere in which summary judgment is favored" prevails. Jack H. Friedenthal and Joshua E. Gardner, "Judicial Discretion to Deny Summary Judgment in the Era of Managerial Judging," *Hofstra Law Review*, 31, No. 1 (2004), 91, 104. Thus, "Summary judgment 'can be a tool of great utility in removing insubstantial cases from crowded dockets, freeing court's trial time for those that really do raise genuine issues of material fact.' [Citations omitted]." *Mills v. First Federal Savings and Loan Association of Belvidere*, 83 F.3d 833, 846 (C.A.7 [Ill.] 1996).

But when courts avail themselves of that "utility" by entering summary judgments that contravene relevant decisions from this Court, that merits review and correction.

CONCLUSION

The summary judgment entered against Petitioner was extraordinarily harsh and unjust. But beyond that, such insupportable judgments potentially undermine the public's assumption that meritorious cases will be fairly heard and, if necessary, tried, rather than being summarily ejected. This would be of particular concern to that substantial segment of the public that contracts for

medical insurance and pays for coverage for increasingly expensive treatments.

Petitioner requests the Court to grant this petition and summarily vacate the judgment below, so that legal counsel may take Petitioner's case to trial.

Respectfully submitted,

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No. _____

In The
Supreme Court of the United States

IRENE M. GESCHKE, INDIVIDUALLY AND
AS EXECUTOR OF THE ESTATE OF
CLARENCE O. GESCHKE,

Petitioner,

vs.

AIR FORCE ASSOCIATION AND
MONUMENTAL LIFE INSURANCE COMPANY,

Respondents.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Seventh Circuit**

APPENDIX

In the

United States Court of Appeals

for the Seventh Circuit

No. 04-3205

IRENE M. GESCHKE, individually
and as Executor of the
Estate of Clarence O. Geschke,

Plaintiff-Appellant,

v.

AIR FORCE ASSOCIATION and
MONUMENTAL LIFE INSURANCE COMPANY,

Defendants-Appellees.

Appeal from the United States District Court
for the Northern District of Illinois, Western Division.
No. 02 C 50271 – **Philip G. Reinhard**, *Judge.*

ARGUED APRIL 7, 2005 – DECIDED SEPTEMBER 23, 2005

Before MANION, ROVNER, and SYKES, *Circuit Judges.*

SYKES, *Circuit Judge.* Clarence Geschke purchased a defined-benefit supplemental cancer insurance policy that promised to reimburse him for "incurred expenses for the cost of blood or blood plasma." Geschke developed leukemia and required numerous blood transfusions. He later died, and his widow, Irene Geschke, filed an insurance claim that included $33,689.81 in expenses for blood and transfusion-related charges such as laboratory testing,

equipment, drugs, administrative fees, and other transfusion expenses. The insurer paid only the cost of the blood product itself, or $1,245.10, and denied coverage for the related charges. Mrs. Geschke filed suit in state court against the insurer and the association that marketed the policy to her late husband, alleging breach of contract, common law fraud, and violation of the Illinois Consumer Fraud Act ("ICFA"). The defendants removed the case to federal district court.

The district court granted summary judgment to the defendants, holding that the unambiguous policy language covered only the cost of the blood itself and not other costs associated with its delivery and administration. We agree with this conclusion. The insurance policy expressly covers only "incurred expenses for the cost of blood or plasma," not related transfusion charges. This coverage language is clear and unambiguous. Accordingly, the insurer did not breach its contract by paying only that portion of the transfusion-related claim that consisted of the cost of the blood. Summary judgment in favor of the defendants on the common law and statutory fraud claims was also appropriate, as there is no evidence of any false statement or deceptive act by the defendants in connection with the sale of the policy.

I. Background

In May 1997 Clarence Geschke enrolled in the Air Force Association's ("AFA") CancerCare Plan, a supplemental cancer insurance policy underwritten by Monumental Life Insurance Company ("Monumental" or "the insurer"). The policy and its associated riders provided defined benefits for certain expenses incurred in the

treatment of cancer, such as hospitalization, hospice care, ambulance services, anesthesia, and blood and plasma. As is relevant here, the "Blood and Plasma Benefit Rider" included in Mr. Geschke's policy provided as follows:

> Upon receipt of due proof that the Covered Person incurred expenses for the cost of blood or blood plasma, we will pay a benefit for these expenses not to exceed the Maximum Benefit shown on the Schedule. The expense of blood or blood plasma incurred while Hospital Confined, as an outpatient or in a free standing facility is eligible for this benefit.

The rider's maximum benefit per Illness Period was $500, but the Schedule of Benefits also indicated that there was no maximum for leukemia. Mr. Geschke paid a quarterly premium of $31.50 for "Member & Family" coverage under the policy and its associated riders.

Mr. Geschke was diagnosed with leukemia in March 1999. On or about April 14, 1999, he sent Monumental a claim form seeking benefits for inpatient and outpatient services provided by Sherman Hospital in 1998 and early 1999. The parties dispute exactly when Mr. or Mrs. Geschke provided Monumental with documentation sufficient to establish Mr. Geschke's cancer diagnosis, as required by the policy, but the issue is no longer material. Sadly, Mr. Geschke died on June 21, 1999.

On October 18, 1999, Mrs. Geschke submitted an updated claim to Monumental for $37,622.37. Of that amount, $33,689.81 related to Mr. Geschke's blood transfusions. In December 1999 Monumental paid $2,114.61 to Mrs. Geschke for hospitalization, surgical, and anesthesia charges. Later, on March 31, 2000, Monumental paid $1,245.10 under the Blood and Plasma Benefit Rider. In a

follow-up letter to Mrs. Geschke dated June 23, 2000, Monumental explained that the Blood and Plasma Benefit Rider did not cover processing or administrative fees, supplies, drugs, or laboratory charges associated with the blood transfusions, and that Monumental was declining to cover the remaining $32,444.71 of the transfusion-related claim.

Mrs. Geschke never cashed Monumental's checks. Instead, she filed suit against Monumental and the AFA in Illinois state court, alleging breach of contract and seeking recovery of benefits under the Blood and Plasma Benefit Rider. She also alleged common law fraud and fraud under the ICFA, 815 ILCS §§ 505/2 *et seq.* The gravamen of both fraud claims is that by failing to explain that the Blood and Plasma Benefit Rider covered only the cost of blood products and not related transfusion expenses, the defendants fraudulently induced Mr. Geschke to purchase the policy and pay premiums. For each of the three claims, compensatory damages were alleged to be "in excess of $20,000 and not more than $50,000." In addition, the two fraud claims included demands for punitive damages. Monumental, a corporation chartered and located in Maryland, removed the case to federal court with the consent of the AFA, a corporation chartered under the laws of the District of Columbia and located in Virginia. Thereafter the defendants moved for summary judgment, which the district court granted.[1]

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[1] The motion for summary judgment was considered upon Geschke's second amended complaint, which was styled as a class action on behalf of all persons who purchased the CancerCare policy within ten years of the commencement of this action and who were denied benefits under the Blood and Plasma Benefit Rider for the same

(Continued on following page)

The district court concluded that although the terms "blood" and "plasma" are not defined in the policy, a reasonable person would understand that the phrase "cost of blood or blood plasma" refers to the cost of the blood product itself and not to other costs associated with the administration of the blood product to a sick person. As such, the court held that Monumental did not breach its contract with Geschke. The court also held that Mrs. Geschke could not carry her burden on the common law and statutory fraud claims because no misrepresentation could be inferred from policy language that was unambiguous, and no other evidence of false statements or deception by the defendants had been presented.

II. Discussion

A. Jurisdiction

The parties did not raise the issue of the district court's jurisdiction, but the defendants argued, both in the lower court and on appeal, that Mrs. Geschke's two fraud claims did not accrue prior to Mr. Geschke's death and therefore abated. We asked at oral argument whether only the breach of contract claim should be considered for purposes of the $75,000 amount-in-controversy requirement for diversity jurisdiction under 28 U.S.C. § 1332(a). We asked whether the damages potentially recoverable in the breach of contract action were above $75,000. After considering the parties' supplemental briefing on this issue,

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reasons the Geschkes' claim was denied. Nothing in the record indicates that a motion for class certification was filed or ruled upon, and the district court's decision on summary judgment does not treat the case as a class action.

we are satisfied that the district court had jurisdiction over Mrs. Geschke's suit.

Whether § 1332 supplies jurisdiction must be determined at the outset of a case; "events after the suit begins do not affect . . . diversity jurisdiction." *Johnson v. Wattenbarger*, 361 F.3d 991, 993 (7th Cir. 2004) (citing *Freeport-McMoRan, Inc. v. K N Energy, Inc.*, 498 U.S. 426 (1991), and other cases). We therefore look to Mrs. Geschke's first complaint, the one the defendants removed to federal court, to see whether the case satisfies the jurisdictional threshold of $75,000. Each of Mrs. Geschke's three claims sought compensatory damages in the amount of $20,000 to $50,000, plus prejudgment interest. The two fraud claims each also demanded an award of punitive damages. "It is the *case*, rather than the *claim*, to which the $75,000 minimum applies." *Johnson*, 361 F.3d at 993. The total amount at stake was thus clearly above that mark.

Whether or not the defendants could succeed with their argument that the fraud claims abated upon Mr. Geschke's death is immaterial to the jurisdictional question. Only if it were *legally impossible* for Geschke to win on claims totaling more than $75,000 would her suit fail for want of jurisdiction. *St. Paul Mercury Indem. Co. v. Red Cab Co.*, 303 U.S. 283, 289 (1938); *Johnson*, 361 F.3d at 993-94. "Legal impossibility" in this sense differs from the standard for dismissal for failure to state a claim under FED. R. CIV. P. 12(b)(6); that there may be a plausible argument that the plaintiff's claims must fail as a matter of law does not mean the court lacks jurisdiction to consider them. *Bell v. Hood*, 327 U.S. 678 (1946); *Johnson*, 361 F.3d at 993-94. If it were otherwise, "defendants would never *win* in diversity cases. They could at best achieve

jurisdictional dismissals, followed by new suits in state court." *Johnson*, 361 F.3d at 994.

The defendants' argument that the fraud claims failed to accrue before Mr. Geschke's death or that if they did accrue, did not survive his death, hardly colors this suit as a "legal impossibility." Though we need not decide the issue, the defendants are probably wrong about the accrual question. *See Knox College v. Celotex Corp.*, 430 N.E.2d 976, 980 (Ill. 1981) (under Illinois' discovery rule, fraud claim accrues "when a person knows or reasonably should know of his injury and also knows or reasonably should know that it was wrongfully caused"). The question of the survival of the punitive damages aspect of the common law and statutory fraud claims is apparently unsettled in Illinois. *See* 755 ILCS 5/27-6 (Illinois Survival Act) (West 1994) ("In addition to the actions which survive by the common law, the following also survive: . . . actions for fraud or deceit."); *Nat'l Bank of Bloomington v. Norfolk & W. Ry. Co.*, 383 N.E.2d 919, 924 (1978) (punitive damages can be recovered if the underlying action is predicated on a statute that specifically authorizes the recovery of punitive damages); *but see Duncavage v. Allen*, 497 N.E.2d 433, 442 (Ill. Ct. App. 1986) (Although Illinois Consumer Fraud Act permits court to grant prevailing plaintiff "any relief which it deems proper," the Act does not explicitly authorize punitive damages, so an action to recover such damages does not survive under the rule of *Nat'l Bank of Bloomington*). In any event, because Mrs. Geschke's claim for punitive damages was not legally impossible at the outset, her lawsuit meets the $75,000 jurisdictional threshold. We therefore proceed to the merits.

B. The Blood and Plasma Benefit Rider

We review the district court's decision on summary judgment de novo, employing the same methodology as the district court. Summary judgment will be granted if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. FED. R. CIV. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). We view the facts and draw all reasonable inferences therefrom in favor of the nonmoving party. *See Franzoni v. Hartmarx Corp.*, 300 F.3d 767, 771 (7th Cir. 2002). However, to survive summary judgment, the nonmoving party may not rely on mere allegations; he must present specific facts to show that a genuine issue of material fact exists. *Celotex*, 477 U.S. at 322-23.

In Illinois, an insurance policy is treated as any other contract and is subject to the same rules of construction. *Horning Wire Corp. v. Home Indem. Co.*, 8 F.3d 587, 589 (7th Cir. 1993) (citing *Dempsey v. Nat'l Life & Accident Co.*, 88 N.E.2d 874, 876 (1949)). Policy language that is clear and unambiguous is accorded its plain, ordinary, and popular meaning. *Travelers Ins. Co. v. Eljer Mfg., Inc.*, 757 N.E.2d 481, 491 (Ill. 2001); *Outboard Marine Corp. v. Liberty Mut. Ins. Co.*, 607 N.E.2d 1204, 1212 (Ill. 1992). Ambiguities should be construed in favor of the insured. *United States Fire Ins. Co. v. Schnackenberg*, 429 N.E.2d 1203, 1205 (Ill. 1981). But "a court should not search for an ambiguity where there is none." *Allstate Ins. Co. v. Smiley*, 659 N.E.2d 1345, 1350 (Ill. 1995). The determination of whether the terms of an insurance policy are ambiguous is made by reference to a reasonable person standard; "the test is . . . what a reasonable person in the position of the insured would understand [the terms] to mean." *Id.* "All the provisions of an insurance contract,

rather than an isolated part, should be read together to interpret it and to determine whether an ambiguity exists." *Schnackenberg*, 429 N.E.2d at 1205.

The policy language at issue in this case is contained in the Blood and Plasma Benefit Rider, which by its terms provides benefits for "incurred expenses for the cost of blood or blood plasma." The question here is whether the phrase "expenses for the cost of blood or blood plasma" confers coverage for blood or plasma costs only, or includes additional expenses associated with the transfusion of the blood product. The policy does not define either "blood" or "plasma," but under Illinois law "[a] policy term is not ambiguous because the term is not defined within the policy or because the parties can suggest creative possibilities for its meaning." *Lapham-Hickey Steel Corp. v. Prot. Mut. Ins. Co.*, 655 N.E.2d 842, 846 (Ill. 1995).

Monumental argues that the "blood or blood plasma" language in the policy is clear and unambiguous and that a reasonable person would understand that the phrase refers only to the cost of the blood product itself and not the various additional charges for equipment and services involved in providing the blood to a medical patient undergoing treatment. Mrs. Geschke argues that it is unreasonable to interpret the rider to cover the cost of blood product but not the services essential for it to be useful. A cancer patient in need of a blood transfusion, she argues, "is not merely handed some blood and told to take it himself as if it were aspirin."

Mrs. Geschke is undoubtedly correct that no cancer patient expects to be handed a pint of blood by medical staff and told to transfuse it himself. But the way medical services are delivered is not the issue here. The issue is

whether Monumental contracted with Mr. Geschke to pay not only for the pints of blood or plasma he received but for the various additional costs associated with the delivery of blood to him. We agree with the insurer and the district court that the "blood or plasma" language is clear on its face and covers only the cost of blood or plasma.

Although it is true that blood and blood plasma are of no practical use to a patient without being transfused, it does not follow that the Blood and Plasma Benefit Rider covers more than the cost of the blood or plasma itself, as only the blood products are specifically mentioned in the rider. "Blood" and "blood transfusion" are not synonyms, nor is the latter term subsumed within the former. The dictionary definition of "blood" is "the fluid that circulates in the principal vascular system of vertebrate animals carrying nourishment and oxygen to all parts of the body and bringing away waste products for excretion. . . . " WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 236-37 (1981). "Plasma" is defined as "the fluid part of blood, or lymph, or milk that is distinguishable from suspended material . . . and that in blood differs from serum." *Id.* at 1732. Nothing in these definitions suggests anything other than what we colloquially refer to as "a pint of blood," nor do they encompass the medical process of transfusion.

The CancerCare Plan at issue here distinguishes the defined benefits included within the policy's coverages from general "treatment" and "cancer treatment." The policy itself does not generally cover cancer treatment, or any treatment at all; according to the "Cancer Insurance Benefit" provision, the policy pays "benefits according to the Schedule of Benefits for Cancer that manifests itself while the Covered Person is insured under this Policy." A special rider was available that did, under limited

circumstances, provide coverage for cancer treatment. Mr. Geschke purchased this rider, called the "Extended Hospital Expenses Benefit Rider." It offered policyholders who purchased the rider a choice: the Plan would pay "Hospital charges for Cancer treatment while a Covered Person is Confined in the Hospital," beginning with the ninety-first day of hospitalization, but only in lieu of all the other benefits provided under the policy. Thus, for policyholders like Mr. Geschke who purchased the Extended Hospital Expenses rider, "cancer treatment" was considered a benefit distinct from all the other defined benefits included in the plan and the other riders. None of the other defined benefits were denominated "treatment" by the policy. This supports the conclusion that the phrase "cost of blood or blood plasma" means the cost of blood or plasma only and not the additional costs associated with treatment-related services such as laboratory testing and transfusion.

Furthermore, if Mr. Geschke's medical bills are any guide at all, the total cost of testing and transfusing the blood products dwarfs the cost of the blood itself by a ratio of roughly 27:1. We must therefore consider whether a reasonable purchaser of this policy would have thought that by paying $31.50 per quarter for "Member & Family" coverage he or she was obtaining coverage not only for blood products but for the full range of services necessary to the transfusion process. Under the Blood and Plasma Rider, the maximum benefit per illness period is $500. However, there is no limit on the benefit for leukemia patients. The parties agree that leukemia treatment generally requires numerous blood transfusions, and the rider's no-limit benefit for leukemia reflects that reality. But not every purchaser of the rider expects to develop leukemia; some are concerned about other forms of cancer.

Given the great disproportion between the cost of blood itself and the costs associated with transfusions, it would be unreasonable for a purchaser of this policy to believe that the $500 maximum in nonleukemia cases covers transfusions as well as blood, for $500 will not pay for the transfusion of a single pint.[2]

Mrs. Geschke maintains that the Illinois Blood and Organ Transaction Liability Act, 745 ILCS §§ 40/1 *et seq.*, supports her reading of the policy because the Act defines blood transfusions as services. The Act reads, in pertinent part:

> The procuring, furnishing, donating, processing, distributing or using human whole blood, plasma, blood products, blood derivatives and products, corneas, bones, or organs or other human tissue for the purpose of injecting, transfusing or transplanting any of them in the human body is declared for purposes of liability in tort or contract to be the rendition of a service.

745 ILCS § 40/2. *See also Brandt v. Boston Sci. Corp.*, 792 N.E.2d 296, 301-02 (Ill. 2003). Mrs. Geschke does not explain why this statute informs our understanding of the phrase "cost of blood or blood plasma" in the insurance rider at issue here. Nor can we see any reason why it

---

[2] According to Geschke's October 18, 1999, claim, Geschke incurred the following expenses for blood and plasma on November 5-6, 1998: $82.70 for "IV Drugs," $225.75 for "Med/Sur Supplies," $1,660.36 for "Laboratory," $165.60 for "Lab/Immunology," $45.95 for "OR Services," and $112.65 for "Blood/Store-Proc." The same itemized charges, and others, were broken out in Sherman Hospital's other billings for blood and plasma. (Apparently $112.65 is the hospital's price for one pint of blood, as other "Blood/Store-Proc" charges were often exact multiples of that amount.) Accordingly, the total cost of transfusing one pint of blood on that particular day was $2,263.06.

should. In *Brandt,* the Illinois Supreme Court described the Act as a response to *Cunningham v. MacNeal Memorial Hospital,* 266 N.E.2d 897 (Ill. 1970), in which the court held that a blood transfusion transaction was the sale of a product for purposes of a strict liability claim. The *Brandt* court noted that the Act overruled *Cunningham* to the extent of precluding warranty and strict liability claims in the context of blood transfusions. *Brandt,* 792 N.E.2d at 301-02. The Act thus has little relevance to the insurance coverage question in this case.

We agree with the district court that the phrase "cost of blood or blood plasma" in the insurance rider is unambiguous and includes only the cost of the blood product itself. Monumental did not breach its contract by declining to pay the administrative, testing, transfusion, and other charges associated with the administration of the blood products.

C. Common Law and Statutory Fraud Claims

The elements of a common law fraud claim in Illinois are: (1) a false statement of material fact made by the defendant; (2) the defendant knew the statement was false; (3) the defendant intended for the false statement to induce the plaintiff to act; (4) the plaintiff relied upon the truth of the statement; and (5) the plaintiff suffered damages as a result of his reliance on the statement. *Connick v. Suzuki Motor Co.,* 675 N.E.2d 584, 591 (Ill. 1996). Mrs. Geschke has not come forward with any evidence that either defendant made a false statement to her husband or affirmatively misrepresented the scope of coverage provided by the Blood and Plasma Benefit Rider. Mrs. Geschke's argument rests on the rider's language and

her contention that the defendants failed to explain that it did not cover all transfusion-related costs. We have concluded that the policy language unambiguously covers only the cost of the blood or blood plasma itself; clear and unambiguous policy language cannot form the basis of a fraud claim. Accordingly, the common law fraud claim was properly dismissed.

The elements of a claim under the ICFA are: (1) a deceptive act or practice by the defendant; (2) the defendant intended that the plaintiff rely on the deception; (3) the deception occurred in the course of conduct involving trade or commerce; (4) the plaintiff suffered actual damage; and (5) the damage was proximately caused by the deception. *Oliveira v. Amoco Oil. Co.*, 776 N.E.2d 151, 160 (Ill. 2002). As with her common law fraud claim, Mrs. Geschke's ICFA claim is premised upon the policy itself and not on any statements or actions by either defendant in connection with the sale of the policy. The blood and plasma rider is not itself deceptive. Summary judgment in favor of the defendants on the ICFA claim was therefore appropriate.

For the foregoing reasons, the decision of the district court granting summary judgment to the defendants is AFFIRMED.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

United States District Court
Northern District of Illinois
Western Division

Irene M. Geschke, et al.

v.

Air Force Association, et al.

JUDGMENT IN A CIVIL CASE

Case Number: 02 C 50271

☐ Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury rendered its verdict.

■ Decision by Court. This action came to trial or hearing before the court. The issues have been tried or heard and a decision has been rendered.

IT IS HEREBY ORDERED AND ADJUDGED that defendants' motion for summary judgment is granted as to plaintiff's Count I breach of contract, Count III common law fraud and Count IV statutory fraud claims. Count II is dismissed. This case is dismissed in its entirety with prejudice.

Michael W. Dobbins,
Clerk of Court

Date: 7/16/2004

/s/ Susan Wessman
Susan M. Wessman,
Deputy Clerk

United States District Court,
Northern District of Illinois

Name of Assigned Judge or Magistrate Judge	Philip G. Reinhard	Sitting Judge if Other than Assigned Judge	
CASE NUMBER	02 C 50271	DATE	7/16/2004
CASE TITLE	GESCHKE vs. AIR FORCE		

[In the following box (a) indicate the party filing the motion, e.g., plaintiff, defendant, 3rd party plaintiff, and (b) state briefly the nature of the motion being presented.]

MOTION:

DOCKET ENTRY:

(1) ☐ Filed motion of [use listing in "Motion" box above.]

(2) ☐ Brief in support of motion due ___.

(3) ☐ Answer brief to motion due ___. Reply to answer brief due ___.

(4) ☐ Ruling/Hearing on ___ set for ___ at ___.

(5) ☐ Status hearing [held/continued to] [set for/re-set for] on ___ set for ___ at ___.

(6) ☐ Pretrial conference [held/continued to] [set for/re-set for] on ___ set for ___ at ___.

(7) ☐ Trial [set for/re-set for] on ___ at ___.

(8) ☐ [Bench/Jury trial] [Hearing] held/continued to ___ at ___.

(9) ☐ This case is dismissed [with/without] prejudice and without costs [by/agreement/pursuant to]

☐ FRCP4(m) ☐ General Rule 21
☐ FRCP41(a)(1) ☐ FRCP41(a)(2)

(10) ■ [Other docket entry] For the reasons stated on the reverse Memorandum Opinion and Order, defendants' motion for summary judgment is granted as to plaintiff's Count I breach of contract, Count III common law fraud and Count IV statutory fraud claims. Count II is dismissed. This case is dismissed in its entirety with prejudice.

(11) ■ [For further detail see order on the reverse side of the original minute order.] /s/ Philip R. Rheinhard

	No notices required, advised in open court.		number of notices	Document Number
	No notices required.			
	Notices mailed by judge's staff.		date docketed	
	Notified counsel by telephone.			
	Docketing to mail notices.		docketing deputy initials	
	Mail AO 450 form.			
	Copy to judge/ magistrate judge.		date mailed notice	
/SEC	courtroom deputy's initials	Date/time received in central Clerk's Office	mailing deputy initials	

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MEMORANDUM OPINION AND ORDER

Plaintiff, Irene Geschke, a citizen of Illinois, individually and as executor of the estate of her late husband, Clarence Geschke, a citizen of Illinois, (hereinafter "decedent"), filed a second amended complaint against defendants, the Air Force Association, a District of Columbia nonprofit corporation with its principal place of business in Arlington, Virginia, (hereinafter "AFA") and Monumental Life Insurance Company, a Maryland corporation with its principal place of business in Baltimore, Maryland, (hereinafter "Monumental"), seeking to recover insurance benefits allegedly due decedent under a group cancer insurance policy serviced and administered by the AFA and underwritten by Monumental. Plaintiff proceeds under three theories: breach of contract (Counts I and II), common law fraud (Count III), and statutory fraud (Count IV). As the amount in controversy exceeds $75,000, this court properly has diversity jurisdiction under 28 U.S.C. § 1332. The parties agree that Illinois law applies. Defendants move for summary judgment.

On summary judgment, the court must view the facts and draw all reasonable inferences in the light most favorable to the non-movant. *Ziliak v. AstraZeneca LP*, 324 F.3d 518, 520 (7th Cir. 2003). Summary judgment is not appropriate where a reasonable jury could return a verdict for the non-movant. *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir. 2003). The court's sole task is to decide, based on the evidence of record, whether there is any genuine issue of material fact in dispute that requires a trial. Only if there is not will the moving party be entitled to summary judgment as a matter of law. *See Payne*, 337 F.3d at 771.

Illinois law requires that a claim for breach of contract establish: (1) the existence of a contract, (2) performance of all conditions to be performed by plaintiff; (3) breach by defendant, and (4) damages to plaintiff as a consequence thereof. *Shubert v. Federal Express Corp.*, 715 N.E.2d 659, 661 (Ill. App. Ct. 1999), In this case, the parties dispute the existence of a genuine issue of material fact with regard to defendants' breach on the Blood and Plasma benefit (hereinafter "the benefit") as stated in Count I.[1] Defendants argue that because the benefit "unambiguously" provides for "expenses for the cost of blood or blood plasma" without providing for "administration and processing fees, laboratory costs, or supplies associated with blood transfusions or analysis" and because defendants indeed paid the "cost of [decedent's] blood or blood plasma," there is no genuine issue of material fact as to the breach and they are entitled to summary judgment as a matter of law.

The construction of an insurance policy and a determination of the rights and obligations thereunder are questions of law which are appropriate subjects for disposition by summary judgment. *Crum and Forster Managers Corp. v. Resolution Trust Corp.*, 620 N.E.2d 1073, 1077 (Ill. 1993). In construing the language of the policy, the court's primary objective is to ascertain and give effect to the intent of the parties to the contract *Traveler's Ins. Co. v. Eljer Mfg.*, 757 N.E.2d 481, 491 (Ill.2001). In order to

[1] Defendants' motion does not discuss the merits of plaintiff's count II breach of contract claim for defendants' alleged failure to pay diagnostic and surgical benefits as promised under the policy. Defendants note that plaintiff's counsel represented that plaintiff would not be pursuing this claim and plaintiff has not disagreed with this statement. Count II, therefore, is dismissed.

ascertain the meaning of the policy's words and the intent of the parties, the court must construe the policy as a whole and take into account the type of insurance purchased, the nature of the risks involved and the overall purpose of the contract. *Traveler's Ins. Co.*, 757 N.E.2d 481 at 491. The test is not what the insurer intended its words to mean, but what a reasonable person in the position of the insured would understand them to mean. *Allstate Ins. Co. v. Smiley*, 659 N.E 2d 1345, 1350 (Ill. App. 1995). When a contract provision is subject to more than one reasonable interpretation, it is ambiguous and must be construed against the drafter. *Bourke v. The Dun & Bradstreet Corp.*, 159 F.3d 1032, 1036 (7th Cir. 1998). On the other hand, where it is susceptible to only one meaning, it is clear and unambiguous, *Bourke*, 159 F.3d at 1037, and a court must afford the words their plain, ordinary and popular meaning, *Outboard Marine Corp. v. Liberty Mutual Ins. Co*, 607 N.E.2d 1204, 1212 (Ill. 1992).

Our primary purpose in construing the instant policy provision is to ascertain the intent of the parties. Initially, we look to the nature of the policy at issue and the risks undertaken by the insurer. *Outboard Marine Corp.*, 607 N.E.2d at 1215. The overall purpose of the contract between plaintiff and defendants is to provide specific, supplemental insurance benefits "to help with the high cost of cancer treatment." Thus, unlike the comprehensive general liability policy at issue in *Outboard Marine Corp.*, this plan is intended to provide limited benefits as identified in the policy and not to provide primary, all-encompassing insurance to cover all of the expenses associated with a course of cancer treatment. *See Outboard Marine Corp.*, 607 N.E.2d at 1215. "Treatment," in fact, is not referenced in any of the materials that specifically

define the Blood and Blood Plasma benefit at issue. Plaintiff admits in her deposition that she and decedent understood at the time of enrollment that the policy provided supplemental coverage that paid, not medical expenses, but specific benefits as identified under the plan. The terms "blood" and "plasma" are not defined within the policy itself so the court must interpret these terms by affording them their plain, ordinary, and popular meanings. *See Outboard Marine Corp.*, 607 N.E.2d at 1215. "'Usual and ordinary meaning' has been stated variously to be that meaning which the particular language conveys to the popular mind, to most people, to the average, ordinary, normal person, to a reasonable person, to persons with usual and ordinary understanding, to a business person, or to a layperson." *Outboard Marine Corp.*, 607 N.E.2d at 1216. Webster's Third New International Dictionary defines "blood" as "the fluid that circulates in the principal vascular system of vertebrate animals" and "plasma" as "the fluid part of blood." To the popular mind, to persons with usual and ordinary understanding, to the reasonable person paying just $31.50 per family per quarter for supplemental insurance to provide specific cancer benefits, the term "cost of blood or blood plasma" reasonably refers only to the cost of the blood product itself.

For these same reasons, interpreting the benefit's language to include the costs of administration and processing fees, laboratory costs, and supplies associated with blood transfusions or analysis, as plaintiff asserts, is not reasonable. In light of the plain, ordinary and popular meaning of the terms "blood" and "plasma," the court cannot find that the parties intended the coverage of this limited supplemental cancer insurance policy to extend so

far as to cover all of the costs associated with a blood transfusion.

The elements required to state a cause of action for common law fraud in Illinois are: (1) a false statement of material fact, (2) defendants' knowledge that the statement was false, (3) defendants' intent that the statement induce the plaintiff to act, (4) plaintiff's reliance upon the truth of the statement, and (5) plaintiff's damages resulting from reliance on the statement. *Connick v. Suzuki Motor Co.*, 675 N.E.2d 584, 591 (Ill. 1996). Failure to prove any of these five elements is fatal to a common law fraud claim.

In this case, plaintiff states that the policy's reference to "expenses for the cost of blood or blood plasma" is a half-truth amounting to a misrepresentation by which defendants intended to mislead decedent into believing the benefit would cover expenses for the processing and administration of blood incidental to a blood transfusion. The court does not find anything about this language to be false or misleading. Defendants' choice of words merely raises a question of contract interpretation, which this court has already decided as a matter of law in favor of defendants. Where a contract provision is found to be unambiguous based upon the plain meaning of the words used in the policy, it cannot be a "false statement of material fact."

To successfully claim a violation of the Illinois Consumer Fraud Act, (hereinafter "the Act"), 815 ILCS 505/2, a plaintiff must prove: (1) a deceptive act or practice by defendant, (2) defendant's intent that plaintiff rely on the deception, (3) the occurrence of the deception in the course of conduct involving trade or commerce, and (4) actual

damage to plaintiff (5) proximately caused by the deception. *Oliveira v. Amoco Oil Co.*, 776 N.E.2d 151, 160 (Ill. 2002). It is not necessary that a plaintiff show actual reliance on the deceptive act or that the defendant committed the deceptive act in bad faith; instead, innocent misrepresentations or omissions intended to induce the plaintiff's reliance are actionable. *Capiccioni v. Brennan Naperville, Inc.*, 791 N.E.2d 553, 558 (Ill. App. 2003). Nevertheless, proof of actual deception of the plaintiff is required. *Shannon v. Boise Cascade Corp.*, 805 N.E.2d 213, 218 (Ill. 2002).

Whether a practice is deceptive or unfair under the Act must be decided on a case by case basis. *Carl Sandburg Village Condominium Assoc. No. 1 v. First Condominium Dev. Co.*, 557 N.E.2d 246, 249 (Ill. App. 1990). Just as the court found above with respect to plaintiff's common law fraud claim, there is no evidence in this case of a deceptive act or practice by defendants. This court has already decided as a matter of law that the terms of the Blood and Plasma benefit are unambiguous in the manner that defendants have asserted. With that said, the benefit is what it is and it cannot at the same time be deceptive or misleading as to plaintiff. By the same token, plaintiff's argument that the benefit runs afoul of the Act's prohibition against "unfair" practices also falls short.

For the reasons stated above, defendants' motion for summary judgment is granted as to plaintiff's Count I breach of contract, Count III common law fraud and Count IV statutory fraud claims. Count II is dismissed. This case is dismissed in its entirety with prejudice.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS

Michael W. Dobbins
CLERK

Office of the Clerk

Irene M. Geschke
924 Mary Anne Street
Woodstock, IL 60098-2285

Case Number: 3:02-cv-50271 Other Court No: 02 AR 294

Title: Geschke v. Air Force Assn

Assigned Judge: Honorable Philip G. Reinhard

MINUTE ORDER of 8/9/04 by Hon. Philip G. Reinhard: Plaintiff moves pursuant to Fed.R.Civ.P.59(e) to alter or amend the judgment entered in this case. The matters raised by this motion do not warrant altering the decision previously reached. AFA's changes to its website, discovered by plaintiff post-judgment, do not show the contract language to be ambiguous. Plaintiff's motion [73-1] is denied. mailed notice

This docket entry was made by the Clerk on August 10, 2004

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United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

October 20, 2005

Before

Hon. DANIEL A. MANION, *Circuit Judge*

Hon. ILANA DIAMOND ROVNER, *Circuit Judge*

Hon. DIANE S. SYKES, *Circuit Judge*

No. 04-3205

IRENE M. GESCHKE, individually and as Executor of the Estate of Clarence O. Geschke,
Plaintiff-Appellant,

v.

AIR FORCE ASSOCIATION and MONUMENTAL LIFE INSURANCE COMPANY,
Defendants-Appellees.

Appeal from the United Stats District Court for the Northern District of Illinois, Western Division.

No. 02 C 50271

Philip G. Reinhard, *Judge.*

ORDER

On consideration of the petition for rehearing, all of the judges on the panel have voted to deny rehearing. It is therefore ordered that the petition for rehearing is DENIED.

(2)

No. 05-946

FILED
MAR 1 - 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The

Supreme Court of the United States

IRENE M. GESCHKE, individually and as Executor of the Estate of CLARENCE O. GESCHKE,

Petitioner,

v.

AIR FORCE ASSOCIATION, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

BRIEF IN OPPOSITION

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STATEMENT OF THE PARTIES PURSUANT TO RULE 29.6

Respondents are Air Force Association ("AFA") and Monumental Life Insurance Company ("Monumental") (Defendants below, hereinafter collectively "Respondents"). AFA is an independent, non-profit organization. Monumental is a corporation owned, in part, by Capital General Development Corporation and First AUSA Life Insurance Company, Inc. No publicly held company owns 10% or more of Monumental's corporate stock.

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RULES

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RESPONDENTS' OBJECTION TO PETITIONER'S PRESENTATION OF QUESTION FOR REVIEW

Petitioner, Irene Geschke, Individually and as Executor of the Estate of Clarence O. Geschke (Plaintiff below, hereinafter "Petitioner"), contends that the proper question before the Court is "[w]hether a federal appellate court may affirm a summary judgment in favor of a medical insurer despite controlling state case law requiring ambiguous provisions in insurance policies to be construed in favor of insureds[.]" Petitioner misconstrues and fundamentally misstates the question presented for review.

The United States Court of Appeals for the Seventh Circuit did not disregard Illinois law requiring courts to construe ambiguities in an insurance contract in favor of an insured. To the contrary, the Seventh Circuit affirmed entry of summary judgment in favor of Respondents because it held that the disputed insurance policy language is unambiguous. (App. 13-14) Thus, correctly restated, the sole question presented for the Court's review is whether the Seventh Circuit, applying Illinois law, correctly held that the relevant policy language is unambiguous and, therefore, does not include the additional insurance benefits claimed by the Petitioner.

INTRODUCTION

Petitioner entirely fails to state any compelling reasons warranting the grant of certiorari. Indeed, Petitioner wholly disregards Supreme Court Rule 10. Petitioner does not contend that the Seventh Circuit's decision conflicts with either a decision of another federal circuit or

a decision of the Illinois Supreme Court; Petitioner does not argue that the Seventh Circuit has decided an important question of federal law that needs to be resolved by this Court; and Petitioner does not suggest that the Seventh Circuit has departed from the accepted and usual course of judicial proceedings.

At most, Petitioner claims the Seventh Circuit misapplied Illinois common law of contracts. By Rule, a petition claiming only a plain misapplication of law is "rarely granted." Sup. Ct. R. 10. This case is no exception.

STATEMENT OF THE CASE

Petitioner's husband, Clarence Geschke, deceased, was a member of the AFA. (Record 59, p. 3) In May 1997, decedent enrolled in the CancerCare Plan sponsored by the AFA. (App. 2) Unlike a general medical liability insurance policy, the CancerCare Plan provided specifically defined supplemental benefits for certain specific expenses incurred in connection with the diagnosis and treatment of cancer. (App. 10-11, 20-21) Both the Respondent and the decedent understood at the time of enrollment that the Plan provided supplemental coverage for specific benefits as identified in the Plan. (App. 21)

After his enrollment, the decedent received a Certificate of Coverage ("Certificate"). (Record 59, pp. 6-7) The Certificate explained that: "[Monumental] would pay benefits according to the Schedule of Benefits for cancer that manifests itself while the covered person is insured under the group policy and any attached Riders." (Record 46, Exh. 10, p. 6) Attached to the Certificate was a "Blood

and Plasma Benefit Rider" ("Rider"), which further provided:

> **BLOOD AND PLASMA BENEFIT RIDER**
>
> This Rider is a part of the Certificate to which it is attached. It is issued in consideration of the application and the payment of any premium. The following Blood and Plasma Rider is added to the Certificate.
>
> > Upon receipt of due proof that the Covered Person **incurred expenses for the cost of blood or blood plasma,** we will pay a benefit for these expenses not to exceed the Maximum Benefit shown on the Schedule. The expense of blood or blood plasma incurred while Hospital Confined, as an outpatient or in a free standing facility is eligible for this benefit.
>
> Benefits are subject to all other terms and conditions of the Certificate. The Rider does not waive, alter or extend any provisions or limitations of the Group Policy except to the extent shown above.

(App. 3, 20-21) (emphasis added) Per the Certificate's Schedule of Benefits, the maximum Blood and Plasma Benefit per illness period was $500, but there was "no maximum benefit for leukemia." (App. 3)

Petitioner's decedent was diagnosed with leukemia in March 1999. *Id.* In April 1999, he submitted a claim to Monumental seeking benefits for certain inpatient and outpatient services. *Id.* Monumental subsequently requested verification of the decedent's clinical diagnosis in order to process the claims. (Record 46, Exhs. 16, 19-20)

On June 21, 1999, the decedent died. (App. 3) Following his death, Petitioner submitted an updated claim in October 1999 to Monumental for $37,622.37. *Id.* Of that amount, $33,689.81 related to the decedent's blood transfusions. *Id.* Because the verification of clinical diagnosis requested in April had not been submitted, Monumental again requested verification of the clinical diagnosis in order to process the claims. (Record 46, Exhs. 27-29)

On December 6, 1999, Petitioner submitted the requested diagnosis verification to Monumental. (Record 59, p. 14) Two weeks later, Monumental paid the eligible benefits under the CancerCare plan for hospitalizations, surgical and anesthesia charges. (App. 3) In March 2000, after receiving confirmation from the hospital as to the accurate charges for the cost of blood and blood plasma, Monumental paid an additional $1,245.10 under the Blood and Plasma Benefit Rider. *Id.*

In May 2000, Respondent challenged Monumental's decision to pay benefits only for the costs of blood and blood plasma and claimed that Monumental should have paid both charges for "blood, platelets and plasma" and charges for "administering the blood plates and plasma." (Record 46, Exh. 34) Monumental responded to Petitioner advising Respondent that, per the applicable Rider, the Blood and Plasma Benefit covered "incurred expenses for the cost of blood and blood plasma[,]" and did not cover "processing or administration fees, supplies, drugs or laboratory charges[.]" (Record 46, Exh. 35)

Petitioner subsequently filed suit alleging that Respondents breached the insurance contract by limiting payment of benefits under the Blood and Plasma Benefit Rider to the cost of blood and blood plasma. Following

discovery, Respondents moved for summary judgment, arguing that the terms of the Plan's Blood and Plasma Benefit Rider were unambiguous and did not cover the additional costs claimed for administration and laboratory analysis of the blood as a matter of law.

After the motion was fully briefed, the district court entered summary judgment in Respondents' favor in July 2004. (App. 21-23) The district court agreed that the purpose of the Plan, unlike a "comprehensive general liability policy," was to provide "specific supplemental insurance benefits." (App. 20) Neither the Plan generally nor the specific Blood and Plasma Benefit Rider referenced a general benefit for cancer "treatment." *Id.* Instead, the Benefit included coverage for "expenses incurred for the cost of blood or blood plasma." (App. 19, 21) Assigning the terms "blood" and "plasma" their "plain, ordinary and popular meanings," the court held that the Blood and Plasma Benefit, "to the reasonable person paying just $31.50 per family per quarter for supplement insurance to provide specific cancer benefits" . . . "reasonably refers only to the cost of the blood product itself." (App. 21) As the language defining the Benefit was unambiguous, the court held that Respondents did not breach the insurance contract. (App. 21-23)

After the district court denied her Rule 59(e) motion, Petitioner filed her notice of appeal on August 24, 2004. (App. 24-25) On September 23, 2005, after briefing and oral argument, the Seventh Circuit affirmed the district court's grant of summary judgment in favor of the Respondents. (App. 23) On October 20, 2005, the Seventh Circuit denied Petitioner's petition for rehearing.

Petitioner filed her Petition for Writ of Certiorari on January 30, 2006, claiming that the Seventh Circuit incorrectly held the CancerCare Plan's Blood and Plasma Benefit was unambiguous or, alternatively, that her opposing interpretation of the Benefit creates a genuine issue of material fact precluding entry of summary judgment.

REASONS FOR DENYING THE PETITION FOR WRIT OF CERTIORARI

Petitioner fails to identify any compelling reason which might even remotely justify grant of certiorari. Petitioner does not assert nor claim that there is a split among the federal circuits on the issue. Neither does Petitioner claim that the Seventh Circuit's decision conflicts with an Illinois Supreme Court decision, departs from the normal course of judicial proceedings, or raises an "important federal question." Petitioner merely disputes the Seventh Circuit's application of Illinois law governing interpretation of an insurance contract like the CancerCare Plan. Notwithstanding Petitioner's dissatisfaction with the Seventh Circuit's decision, a federal appellate court's routine application of well-settled state contract law is wholly insufficient to warrant certiorari.

In essence, Petitioner only argues that the Seventh Circuit's "analysis entirely fails to establish the absence of an ambiguity," and thus, her claim that the Benefit is "just obviously ambiguous" remains unrebutted. (App. 7) This argument is fundamentally unsound.

Illinois law does not assume a contract of insurance is ambiguous; rather it admonishes courts not to read an

ambiguity into a policy or invent one where none exists. *Horning Wire Corp. v. Home Indem. Co.*, 8 F.3d 587, 589 (7th Cir. 1993), *citing Dempsey v. Nat'l Life & Accident Ins. Co.*, 404 Ill. 423, 426, 88 N.E.2d 874, 876 (1949). Under Illinois law, "[a] court's primary objective in construing the language of the policy is to ascertain and give effect to the intentions of the parties as expressed by the terms of the agreement." *Am. States Ins. Co. v. Koloms*, 177 Ill.2d 473, 479, 687 N.E.2d 72, 75 (1997). It is the insured's burden, not the burden of the court, to prove eligibility for insurance benefits. *UNR Indus., Inc. v. Cont'l Cas. Co.*, 942 F.2d 1101, 1108 (7th Cir. 1991), *citing St. Michael's Orthodox Catholic Church v. Preferred Risk Mut. Ins.*, 146 Ill.App.3d 107, 110, 496 N.E.2d 1176, 1178 (1st Dist. 1986).

Petitioner claims that it defies common sense to interpret the Blood and Plasma Benefit to cover the "cost of blood or blood plasma," but not additional costs for preparing and transfusing the blood transfusion. (App. 9) Petitioner reasons that a patient is not expected to transfuse blood themselves, but must pay additional medical costs for this service. *Id.* As the Seventh Circuit correctly recognized, however, the issue is not the way medical services may be delivered, but rather what costs are covered by the terms of the insurance contract. (App. 9-10) Although blood or blood plasma may be of no practical use without being transfused, it does not follow that the insurance agreement covers more than what it specifically states. (App. 10)

As stated in the Plan's specific Blood and Plasma Benefit Rider, the Benefit pays "incurred expenses for the cost of blood or blood plasma." (App. 3, 20-21) Affording "blood" and "plasma" their common dictionary meaning, neither term is synonymous with the medical process of

transfusion. (App. 10) Because the Rider does *not* make any reference whatsoever to costs for transfusion services (or any other processing or laboratory costs claimed by Petitioner), these additional expenses are plainly not covered. *Id.*

Petitioner also argues that the Blood and Plasma Benefit Rider is made ambiguous by the Plan's "repeated reference to 'treatment[,]'" Petitioner's argument, however, disregards the Plan's plain language. The CancerCare Plan does not confer a general benefit for cancer "treatment." (App. 10) Indeed, nowhere does the word "treatment" appear in either the Schedule of Benefits or, more specifically, in the Blood and Plasma Benefit Rider. (App. 10-11)

The fact that Petitioner has proffered a different interpretation of the contract does not, as she claims, create a material fact precluding summary judgment. (App. 10-11) It is fundamental that "interpretation of an insurance policy is a question of law that is an appropriate subject for disposition by summary judgment" *Jupiter Aluminum Corp. v. Home Ins. Co.*, 225 F.3d 868, 873 (7th Cir. 2000). A contract is not ambiguous simply because the parties do not agree on the meaning of its terms. *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d 1032, 1036 (7th Cir. 1998). Here, the Blood and Plasma Benefit Rider plainly states that the Benefit paid for the "cost of blood or blood plasma." As the Seventh Circuit recognized, this language could not reasonably be construed to mean the Benefit paid expenses for anything other than what it expressly provided. (App. 10-13) Because the Benefit Rider was unambiguous, Respondents were entitled to summary judgment as a matter of law.

The Seventh Circuit Court of Appeals properly applied Illinois law. Petitioner's Petition presents no reason, let alone a compelling reason, to warrant granting a writ of certiorari.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari must be denied.

Respectfully submitted,

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No. 05-946

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In The

Supreme Court of the United States

IRENE M. GESCHKE, INDIVIDUALLY AND AS EXECUTOR OF THE ESTATE OF CLARENCE O. GESCHKE,

Petitioner,

v.

AIR FORCE ASSOCIATION AND MONUMENTAL LIFE INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

REPLY TO BRIEF IN OPPOSITION

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RESPONDENTS' OBJECTION MISAPPREHENDS THE QUESTION PETITIONER PRESENTS FOR REVIEW AND ADDRESSES IN THE PETITION FOR CERTIORARI

The United States Court of Appeals for the Seventh Circuit in its *de novo* review of the summary judgment entered in this case ignored Illinois law governing contract interpretation, and disregarded or misstated pertinent evidence in the record as to the meaning of the contract language in dispute. "Contract interpretation, including the question of whether a contract is ambiguous, involves conclusions of law." *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d 1032, 1036 (C.A.7 1998). The Circuit's error in how it determined a matter of law is the subject of the petition for writ of certiorari, and is an issue within the question presented for review. And of course the question raised is not, contrary to Respondents (Brief in Opposition [hereinafter, "Brief"] pp. 1, 2, 6, 8) merely whether the Circuit's interpretation of the contract language was correct (although it obviously was not).

Respondents' Brief does nothing to demonstrate that in interpreting that language the Seventh Circuit followed controlling state law, and that the Circuit's affirmation of the summary judgment was in any way a defensible ruling.

RESPONDENTS' RESTRICTIVE VIEW OF RULE 10 IS WRONG AND DISREGARDS THE COURT'S DISCRETION WITH REGARD TO PETITIONS FOR CERTIORARI

Contrary to the Respondents (Brief pp. 1, 2, 6), the Supreme Court emphasizes in Rule 10 that the possible reasons stated therein for granting a petition for writ of certiorari neither control nor fully measure the Court's judicial discretion. In this case, Petitioner believes that the question presented for review and the argument

(citing pertinent evidence) support granting the petition pursuant to the third reason described in Rule 10(a).

The Court is aware that in exercising its judicial discretion it has granted certiorari in cases of "egregious error" involving "extraordinarily harsh and unreasonable results on the record." Stephen M. Shapiro "Certiorari Practice: The Supreme Court's Shrinking Docket" Mayer, Brown, Rowe & Maw Appellate.Net Supreme Court and Appellate Practice Group, www.appellate.net, pg. 6; ___, "Granting Certiorari: How does the Supreme Court decide which cases to decide?", search.yahoo.com (referencing Perry, H.W., *Deciding to Decide, Agenda Setting in the United States Supreme Court*, Cambridge, Mass.: Harvard University Press, 1991). In this case, the Seventh Circuit's affirmation of a summary judgment, based on its erroneous approach to construing contract language, creates a "compelling reason" for granting the petition.

REPLY TO POINTS RAISED IN BRIEF IN OPPOSITION

Respondents' Points Concerning Blood and Plasma Benefit Rider Treat the CancerCare Plan Contract as a Collection of Separate, Isolated Documents, Not a Single Unified Whole

According to the Seventh Circuit: (1) The CancerCare Plan was articulated in a policy and a number of separate and isolated riders; (2) Only one rider actually provided any coverage for cancer treatment; (3) The balance of the CancerCare Plan had nothing to do with providing "cancer treatment or any treatment at all."; (4) Consequently, the "Blood and Plasma Benefit Rider" language – "expenses for the cost of blood and blood plasma" – whose meaning the parties dispute is to be understood as covering only the cost of the physical substance, not typing it and administering it to the cancer patient. (Petition for Certiorari [hereinafter "Pet."] Appendix [hereinafter "App."] 10-11)

Respondents argue certain points concerning the "Blood and Plasma Benefit Rider" that are grounded on the Seventh Circuit's view of the CancerCare Plan as consisting of separate, isolated documents – the policy, the riders, the amendments – rather than together, as one single contract. (Brief pg. 8) But the opening sentence in every one of the seven riders states, "This Rider is a part of the Policy to which it is attached." And each of the five amendments contains language relating it back to the policy. (The riders and amendments are in Exhibit D to the petitioner's opening brief to the Seventh Circuit.)

"Illinois law requires that we do not look at the contested language in isolation. We 'examine [the contract] as a whole, giving effect, to the extent possible, to all contractual provisions.' *O'Rourke v. Access Health, Inc.*, 282 Ill.App.3d 394, 218 Ill.Dec. 51, 57, 668 N.E.2d 214, 220 (1996) (internal citations omitted)." *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d at 1038. "All the provisions of an insurance contract, rather than an isolated part, should be read together to interpret it and to determine whether an ambiguity exists." *United States Fire Insurance Co. v. Schnackenberg*, 88 Ill.2d 1, 5, 429 N.E.2d 1203, 1205, 57 Ill.Dec. 840 (Ill. 1983). (App. 8-9) This law simply was not followed by the Seventh Circuit.

In the Seventh Circuit's Opinion in this case, in the key passage therein where the Circuit actually interprets the language in question, the Circuit asserts that only one rider, the "Extended Hospital Expenses Benefit Rider," did "under limited circumstances, provide coverage for cancer treatment." According to the Circuit, that made it a "special rider" providing a cancer treatment benefit "distinct from all the other defined benefits included in the plan and the other riders." (App. 10-11) But contrary to the Circuit, the insurer (Monumental Life Insurance Company) who drafted the "Extended Hospital Expenses Benefit Rider" did not designate it as "special" or distinguish it from the policy's other amendments and its riders. There is absolutely no language in the rider (and the

Seventh Circuit does not point to any) that states or implies that policyholders or enrollees in the CancerCare Plan could separately purchase the rider, or had a "choice" between benefits provided by that rider or "all other benefits provided under the policy." (App. 10-11) Nothing in the language of that rider even suggests that the cancer treatment referenced therein "was considered a benefit distinct from all the other defined benefits included in the plan and the other riders." (App. 11)

A contract containing language whose meaning is disputed "'is not ambiguous if a court can discover its meaning simply through knowledge of those facts which give it meaning as gleaned from the general language of the contract.' . . . [citing *Flora Bank & Trust v. Czyzewski*, 222 Ill.App.3d 382, 164 Ill.Dec. 804, 809, 583 N.E.2d 720, 725 (1991)]" *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d at 1036. "A court's primary objective in construing the language of the [insurance] policy is to ascertain and give effect to the intentions of the parties as expressed in their agreement." *American States Insurance Co. v. Koloms*, 177 Ill.2d 473, 479, 687 N.E.2d 72, 75, 227 Ill.Dec. 149 (Ill. 1997).

Those two Illinois cases presume of course that in fairness the court will issue a ruling based on facts apparent from the record, and which cast particular light on that disputed meaning of the language. Thus, for example, the Seventh Circuit in *Bourke* (which concerned interpretation of an employment compensation contract) repeatedly cited to the specific location in the contract of provisions pertinent to the interpretation controversy, and thoroughly and methodically analyzed the language in those provisions.

Respondents' Point That CancerCare Plan Does Not Cover All Cancer Treatment is Moot, and Does Not Address Seventh Circuit's Erroneous Holding That CancerCare Does Not Cover Any Cancer Treatment

The Respondents' point that "The CancerCare Plan does not confer a general benefit for cancer 'treatment.' (App. 10)" (Brief pg. 8) is moot, because that is something the Petitioner has never denied or disputed. According to the Seventh Circuit (App. 10), the CancerCare Plan provides certain specified benefits, but the CancerCare Plan "policy itself does not generally cover cancer treatment **OR ANY TREATMENT AT ALL**" (emphasis added). That last part is quite untrue, as a check of the policy shows. Respondents follow the Seventh Circuit and continue to deny what is true – that the CancerCare Plan's purpose is to provide benefits for certain cancer treatments. Petitioner is therefore justified in specifically identifying where the CancerCare Plan group insurance policy (in the record as Appendix Exhibit D attached to the Appellant's Opening Brief in petitioner's appeal to the Seventh Circuit) repeatedly references the provision of benefits for treatment of cancer (emphases added in uppercase bold):

> Pg. 5, "CONFINED OR CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and **TREATMENT** of a Physician."
>
> Pg. 5, "HOSPITAL means an institution which meets all of the following requirements: . . . (2) it must give 24 hour medical care, diagnosis and **TREATMENT** to the sick or injured on an in-patient basis for which a charge is made; . . . "
>
> Pg. 6, "PHYSICIAN means a person licensed by the state in which he is resident to practice

the healing arts. He must be practicing within the scope of his license for the service or **TREATMENT** given."

Pg. 8, "CANCER INSURANCE BENEFIT . . . If the Covered Person receives **TREATMENT** for cancer, but positive diagnosis is not made during his lifetime, we will make payment if positive diagnosis is made after death."

Pg. 8, "HOSPITAL CONFINEMENT DAILY BENEFIT. We will pay the following benefit for Cancer **TREATMENT** provided the Covered Person is Hospital Confined. . . . Upon receipt of due proof that a Covered Person is Hospital Confined for the **TREATMENT** of Cancer, we will pay the benefit shown on the Schedule for each day of Confinement."

Pg. 8, "EXCLUSIONS. Benefits will not be paid under this Policy and any attached Rider for any expenses which result from: . . . (3) **TREATMENT** or services performed outside of the United States."

Pg. 8, "PRE-EXISTING CONDITION LIMITATION. No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as a Cancer that was positively diagnosed within five years prior to the Covered Person's Effective Date of Coverage under this Policy, or a Cancer for which **TREATMENT** has been received before the Covered Person has been insured for 30 days from his Effective Date of Coverage. We will, however pay benefits for Cancer diagnosed and treated within the first 30 days the Covered Person has been insured. Expenses for such **TREATMENT** are payable only if incurred after coverage has been in force for 12 consecutive months from the Effective Date."

Pg. 10, "CHOICE OF PHYSICIAN. The Covered Person is free to be **TREATED** by any Physician he chooses."

> "SKIN CANCER BENEFIT RIDER. . . . Upon receipt of due proof that a Covered Person incurred expenses for **TREATMENT** of Skin Cancer, we will pay the expenses of its removal."
>
> "SURGICAL AND ANESTHESIA BENEFIT RIDER. . . . Upon receipt of due proof that a surgical procedure for the **TREATMENT** of Cancer is performed on a Covered Person, we will pay the expense incurred for the procedure, including post-operative attendance. . . . For the purposes of this Rider, Operative Session means the continuous period of time during which surgical procedures are performed for the **TREATMENT** of Cancer, regardless of the number of procedures or the number of surgical incisions."
>
> "HOSPICE CARE BENEFIT RIDER. . . . Upon receipt of due proof that a Covered Person, following a Covered Hospital Confinement which lasted at least 3 consecutive day, incurs expenses for **TREATMENT** in a Hospice, we will pay the amount shown on the Schedule."
>
> "AMENDMENT. . . . The following definitions are added to the Definitions section: . . . **TREATMENT** means medical and surgical care by a licensed provider to detect or cure Cancer. This includes examination, diagnostic procedures, surgery (including pre- and post-operative care), prescribed medication, **AND THE APPLICATION OF REMEDIES AND THERAPY.**"

"Reference to the purpose of a contract can be a useful aid in construction. '[I]f the principal purpose of the parties is ascertainable it is given great weight.' Restatement (Second) of Contracts § 202(1)." *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d at 1039.

Illinois law requires that provisions of an insurance agreement be interpreted in the factual context of the case. *Indiana Insurance Co. v. Pana Community Unit School District No. 8*, 314 F.2d 895, 900 (C.A.7 [Ill.] 2002).

(Pet. pg. 7) Petitioner has also pointed to pitch letters and brochures mailed by the Respondent to prospective enrollees, to promote the CancerCare Plan, which are persuasive evidence that the purpose of the CancerCare Plan was clearly represented to be and was understood to be to provide benefits for certain cancer treatments. (Pet. pp. 8-9) And at a still more basic level, the name of the plan is CancerCare, and "care" means "treatment." So clearly, to the reasonable person, all CancerCare Plan benefits are properly understood as being for various services constituting treatment of cancer.

"The determination of whether the terms of an insurance policy are ambiguous is made by reference to a reasonable person standard; 'the test is . . . what a reasonable person in the position of the insured would understand [the terms] to mean.' Id. [i.e., *Allstate Insurance Co. v. Smiley*, 276 Ill.App.3d 971, 659 N.E.2d 1345, 1350, 213 Ill.Dec. 698 (2 Dist. 1995)]" (App. 8)

Respondents' Points Concerning Omission in the "Blood and Plasma Benefit Rider" of the Word "Treatment" and Any Reference to Blood Processing and Transfusion Costs are Overruled by the Circumstances Surrounding the CancerCare Plan

Respondents make two points concerning the "Blood and Plasma Benefit Rider": it does not refer to blood processing and transfusion costs, and the word "treatment" does not appear there or in the policy's "Schedule of Benefits." This, according to the Respondents, supports their argument against interpreting "expenses for the cost of blood and blood plasma" as encompassing treatment using those substances. And the Seventh Circuit similarly attached significance, despite all evidence to the contrary, to the fact that "None of the other benefits were denominated 'treatment' by the policy. This supports the conclusion that the phrase 'cost of blood or blood plasma' means the cost of blood or plasma only and not the additional

costs associated with treatment-related services such as laboratory testing and transfusion." (App. 11)

But the conclusion reached by Respondents and the Seventh Circuit is not sustainable in view of the circumstances surrounding the CancerCare Plan. As has been demonstrated, the Plan is all about providing specified benefits for certain treatments for cancer. And it was the insurer who, after all, drafted the CancerCare Plan policy, including the ambiguous passage at issue in this case. Typing and transfusing blood and blood plasma are clearly treatment for cancer. The CancerCare Plan policy provisions are to be read and understood together, because the CancerCare Plan policy is a single, unified contract, not an assemblage of separate, isolated documents. So clearly, under all of these circumstances, a reasonable person could understand the language "expenses for the cost of blood and blood plasma" as covering the costs of matching the blood or blood plasma type to the patient and then administering the blood or plasma to a patient for, as in this case, treatment of leukemia.

The "Blood and Plasma Benefits Rider" language at issue in this case is therefore ambiguous. If an insurance policy's terms are susceptible to more than one meaning, "they are considered ambiguous and will be construed strictly against the insurer who drafted the policy." *Commonwealth Insurance Co. v. Stone Container Corp.*, 351 F.3d 774, rehearing denied (C.A.7 [Ill.] 2003). When competing reasonable interpretations of a policy exist, a court is not permitted to choose which interpretation it will follow, but must construe the policy in favor of the insured and against the insurer who drafted it. *Employers Insurance of Wausau v. Ehlco Liquidating Trust*, 186 Ill.2d 127, 141, 708 N.E.2d 1122, 1130, 237 Ill.Dec. 82, rehearing denied, on remand, 309 Ill.App.3d 730, 723 N.E.2d 687, 243 Ill.Dec. 384, appeal denied, 188 Ill.2d 563, 729 N.E.2d 495, 246 Ill.Dec. 122 (Ill. 1995). (Pet. pg. 7) But in this case, the Seventh Circuit did just the opposite.

CONCLUSION

To proceed as the Seventh Circuit did, considering only selected evidence in the record and then misstating that evidence, and to then find an absence of ambiguity, amounts to disregarding established Illinois law that ambiguities in insurance contracts must be construed in favor of the insured. The Seventh Circuit's ruling undermines that established law, and creates precedent that is hostile to the interests of all insureds who pay for health insurance contracts.

The Seventh Circuit's finding also created the basis for affirming the summary judgment entered by the district court. The Circuit's error deprived Petitioner of her right to have her meritorious case tried. Stripping a plaintiff of the right to have a meritorious case tried, and doing so based on an egregious misapprehension of the pertinent facts, is extraordinarily arbitrary and unfair to the plaintiff.

For these reasons, and given Respondents' inability to raise a plausible defense of the Seventh Circuit's ruling, Petitioner maintains her request that the Court grant her petition and summarily vacate the judgment entered in the district court, so that legal counsel may take her case through trial.

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